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ABSTRACT

African American college students are among the age group of African Americans who are at significantly higher risk for heterosexual transmission of human immunodeficiency virus (HIV). Much of the research in this area suggests that for the majority of these students, there is little or no relationship between the knowledge of HIV transmission and safer sexual behavior. Simply being knowledgeable about HIV transmission is not sufficient to change risky sexual behavior. None of the research clearly elucidates the factors that serve as barriers to those who either fail to use condoms or do so inconsistently. Based on this literature review, it is apparent that the barriers to practicing safer sex are complex. Several recommendations are included on developing HIV prevention programs for African American college students. HIV prevention might be best included within the context of more general health promotion campaigns. Sustained effort is needed to build trust and credibility between the African American community and prevention program staff. Health beliefs and how they may impact preventive measures need to be identified. Privacy and ease of accessibility to HIV testing must be assured. Peer influence must be taken into account, and education about use and availability must be considered. (Contains 23 references.) (JDM)

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by

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African American College Students: Establishing HIV Prevention Programs

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ABSTRACT

African American college students are among the age group of African Americans with significantly higher heterosexual transmission of HIV. Many African American college students experiment with sex. They tend to have multiple partners and use condoms inconsistently, if they use them at all. Much of the research in the area suggests that for the vast majority of African American college students there is little or no relationship between knowledge of HIV transmission and safer sex behavior. Thus, simply being knowledgeable about HIV transmission is not sufficient to change risky sexual behavior. None of the research fully elucidates the factors that serve as barriers to those who either fail to use condoms at all or do so inconsistently. Based on the literature reviewed, it is apparent that the barriers to engaging in safer sex are often complex and subtle. Given the complexity and subtitles in assessing the nature of the barriers to practicing safer sex, the author provides a number of recommendations for consideration in the development of HIV prevention programs for African American college students.

In America, HIV/AIDS has shifted from a disease found predominately among white gay males to one that disproportionately affects African Americans. Presently, HIV/AIDS is devastating the African American community (CDC, 1999a; Tewksbury and Moore, 1997). Although African Americans represent only 12% of the U.S. population, they account for 45% (21,752) of the 48,269 cases of AIDS reported in 1998. In 1998, the rate of AIDS cases among African Americans was 66.4 per 100,000 population which is more than twice the rate among Hispanics and eight times that for whites. In the 25 states with integrated reporting systems, African Americans represent a high proportion (45%) of the AIDS cases diagnosed and even a higher proportion (57%) of all HIV diagnoses. Further, among young persons age 13 to 24, 63% of those diagnosed with HIV are African Americans. In fact, from 1985 to1998 the rate of AIDS among adolescent and adult women has more than tripled from 7% to 23%. The

epidemic has had its greatest impact on women of color. African American women and Hispanic women account for 77% of AIDS cases reported among women to date in the U.S. (CDC, 1999b).

In keeping with national trends, in Louisiana, the gap between the case rate among African Americans and white Americans continues to increase. In 1997, Louisiana ranked 9th among states with the highest AIDS rates. Among U.S. cities, New Orleans ranked 11th while Baton Rouge ranked 19th in the number of diagnosed cases of AIDS. Sixty-nine percent of the cases of AIDS diagnosed in 1997 occurred in the African American population. African Americans accounted for 73% of the HIV cases diagnosed in 1997. Furthermore, a steady increase in the number of HIV/AIDS cases has been noted in the heterosexual population of the state. In 1990, 5% of the cases were among heterosexuals, but by 1997 it had grown to 18%, more than a threefold increase. While the number of AIDS cases appear to have reached a plateau and the rate of deaths from AIDS has declined in the white community the rate continues to rise among African Americans.

Bazargan, et al (2000) suggest that, the next shift in transmission rates will be experienced by African American college students. That is, African American college students who engage in risky sexual behavior are at a much greater risk of contracting HIV than their white counterparts. According to Bazargan, et al (2000) the significantly higher HIV rates in the African American community, particularly among young adults, is a major factor that places African American college students at a greater risk of contracting HIV. That is, African American college students are similar to other members of their community in sharing attitudes about the origins of HIV/AIDS and the

nature of HIV/AIDS based on their history in the United States. They also share the continuing black-white health disparities that can be linked to the persistence of HIV/AIDS in the African American community. In addition, many African American college students experiment with sex. They tend to have multiple partners and use condoms inconsistently, if they use them at all. Experimentation with sex is quite common among this age group as is their personal belief in their own invincibility.

After reviewing a decade of literature on HIV/AIDS risk in heterosexual college students, Bazargan and his colleagues (2000) conclude that college students continue to engage in behaviors that place them at high risk of HIV/AIDS. These researchers suggest that the college environment "provides students with a sense of new independence, self-determination and strong peer pressure to experiment with a variety of sexual behavior" (Bazargan, et al, 2000, p. 391). Based on this analysis, college students are more likely to have multiple sexual partners and less likely to consistently use condoms. Thus, college students in general and African American college students, in particular, engage in behaviors likely to place them at high risk of contracting HIV. The long delay from the time of initial infection to the manifestation of symptoms may lead college students to mistakenly believe that they are immune to HIV.

Much of the early research on African American college students and HIV risk was descriptive in nature focusing on knowledge of HIV/AIDS transmission (Johnson, Hinkle, Gilbert, and Grant, 1992; Carroll, 1991; Ehde, Holm, and Robbins, 1995), attitudes towards condom use (Beckman, Harvey, & Tiersky, 1996; Johnson, Grant, Hinkle, Gilbert, & Grant, 1992) and the degree to which at-risk behaviors occurred (Johnson, Douglas and Nelson, 1992; Thomas, Gilliam, Iwrey, 1989). In one of the more

comprehensive studies done to date, Bazargan, et al (2000) investigated the effect of HIV knowledge, motivation and behavioral skills on HIV risk-taking behaviors. They found that the greater the HIV knowledge (sexual acts), less age, nonmonogamous relationship, more experience using condoms and the greater the behavioral skills (negotiating safer sex behavior) and male gender were significant predictors of condom use. However, much of the research in the area suggests that for the vast majority of African American college students there is little or no relationship between knowledge of HIV transmission and safer sex behavior (Braithwaite, Stephens, Sumpter-Gaddist, Murdaugh, Taylor, & Braithwaite, 1998; Carroll, 1991; Johnson, Grant, Hinkle, Gilbert, Willis, & Hoopwood, 1992; Johnson, Hinkle, Gilbert & Grant, 1992). Thus, simply being knowledgeable about HIV transmission is not sufficient to change behavior.

Bazargan, et al (2000) research seems to distinguish the characteristics of those African American college students who consistently use condoms (greater HIV knowledge, less age, nonmonogamous relationship, more experience using condoms and the greater the behavioral skills). However, the research does not elucidate the factors that serve as barriers to those who either fail to use condoms at all or do so inconsistently. Based on a pilot study conducted by Duncan and Miller (1999) using the Nominal Group Technique (NGT), it was apparent that the barriers to engaging in safer sex are often complex and subtle. One finding of this pilot research was that trust issues often interfere with some African American college students' ability to engage in safer sex. More specifically, it was stated that suggesting the use of condoms could be interpreted by a partner as an indication that the other person was cheating or implying that the other

partner has an STD. These findings are consistent with that of other researchers that found the suggestion to use condoms adversely affected the relationship and identity often being interpreted as evidence of bisexuality, promiscuity, intravenous drug use or having some STD (Afifi, 1999; Wingood, Hunter-Gamble, & DiClemente, 1993).

Another finding by Duncan and Miller (1999) was that there was some skepticism expressed about the effectiveness of free condoms. Free condoms were thought to be less reliable than those that could be purchased. The genesis of this skepticism may be rooted in the historical experiences of African Americans in this country. Unequal treatment by the medical profession coupled with past abuse (Tuskegee Syphilis Study) sustains the distrust among African Americans for the medical system, particularly public health.

Efforts to educate and promote safer sex practices as a means of preventing the spread of HIV have met with some disappointing results (Afifi, 1999; Braithwaite, Stephens, Sumpter-Gaddist, Murdaugh, Taylor, & Braithwaite, 1998; Hall, 1990). Despite years of emphasizing condom use, the frequency of using condoms remains low. Only 40% of men and 20% of women use condoms with casual sexual partners on a consistent basis and only 57% of men and 44% of women indicated having ever used a condom. In addition to education, an understanding of more subtle factors that are involved in condom use and safer sex practices must be elucidated if more effective methods of prevention are to be found (Braithwaite, et al., 1998; Gilmore, Delamater, & Wagstaff, 1996). It appears clear that sexual communication and the ability to negotiate safer sex (condom use) are important ingredients for inclusion in HIV prevention programming (Afifi, 1999; Bazargan, et al, 2000; Wingood, Hunter-Gamble, & DiClemente, 1993).

Following are some general recommendations for establishing HIV/AIDS prevention programs for African American college students.

1. Considerable thought has to be given to attracting African Americans to HIV/AIDS prevention programs. The stigma of homosexuality and intravenous drug use continue to be associated with risk of HIV and thus, many African American youth are less likely to involve themselves in that kind of programming. HIV prevention might be best included within the context of more general health promotion campaigns or similar less stigmatizing activities.
2. Sustained effort is needed to build trust and credibility between the African American community and the prevention program staff. Again, the potential stigma of being labeled or identified as at-risk can be a major deterrent and college students' belief that they are not at-risk has to be challenged and dispelled. If individuals do not believe that they have some risk, they are less likely to take precautions against that risk.
3. Identify health beliefs and how these beliefs may hinder HIV prevention efforts is essential.
4. Continued efforts to educate must take place based on need assessment (elimination of myths and barriers to prevention). For example, students may have the mistaken notion that they can identify people who are HIV positive from those that are not. Also, they may see some sexual activities such as oral sex as risk free or that free condoms are less effective than those that can be purchased.

5. Privacy and ease of accessibility to HIV testing must be assured and incorporated within prevention programming. Knowledge of HIV status can be a motivator for youth to remain HIV negative by promoting the use of condoms
6. Sexual communication, negotiation, conflict resolution and refusal skills should be considered for inclusion in prevention programs to eliminate potential barriers to practicing safer behavior. The intention to use condoms no matter how deeply felt will not occur unless the individual is able to communicate and negotiate their use with their partner. These are skills that can be taught.
7. Focus on secondary prevention is also needed to reduce the risk of already infected persons from infecting others and referral to treatment programs for those testing HIV positive. It is important to recognize that HIV testing may identify those who are HIV positive and in need of counseling and referral to treatment as well as secondary prevention programming.
8. Peer influences must be taken into account and incorporated into prevention programming if behavior change is to be extended and maintained over time.
9. Demonstrate the proper use of condoms, identifying circumstances when they should be used (traditional coitus, during oral and anal sex) as well as stored are important components if condoms are to be effective prevention measure.
10. Make condoms readily accessible, promote view of condoms not limiting sexual pleasure (availability of condoms that provide greater sensitive and larger size condoms for comfort) and as an effective HIV prevention measure.
11. Develop strategies to minimize the impact of substance use on the decision to employ condoms.

12. Information and referrals should be available at various points where gatekeepers (university health center staff, dormitory resident assistants) may come in contact with targeted populations.
13. Promote active involvement of students in their own health care.
14. Develop relationships with community organizations (churches, fraternities, sororities) as a means of disseminating HIV prevention information.
15. Develop relationships with community experts who are influential to mobilizing community interest and support to assist in disseminating information about HIV prevention to the target populations.

The aforementioned recommendations are made to prompt a comprehensive consideration of the issues involved in developing effective programs for HIV prevention. Effective HIV prevention programming is often very complex and involves subtle issues. Although African Americans share a common history and many similarities, they are not a monolithic group. There are differences that will distinguish one subgroup from another and what will work for one group will not necessarily be appropriate for another.

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